IS TODAY'S VISIT WORK-RELATED?

IF YES: DO NOT COMPLETE THIS FORM!
NOTIFY THE FRONT DESK STAFF IMMEDIATELY

PATIENT INFORMATION: Patient Name: Date of Birth:

Home Email: Sex: ◯M ◯F SSN#

Street: Apt # City: State: ZIP:

Home Ph # Cell Ph # Employer Name: Work Ph #

EMERGENCY CONTACT: Name: Phone #:

DUE TO FEDERAL GOVERNMENT REQUIREMENTS PLEASE CIRCLE THE FOLLOWING FOR THE PATIENT: ◯ Prefer not to Answer

RACE: Native American or Alaska Asian Black or African American White Native Hawaiian or Pacific Islander Other

ETHNICITY: Hispanic or Latino Not Hispanic or Latino PREFERRED LANGUAGE: English Spanish Other

BEST FORM OF CONTACT: ◯ Home # ◯ Cell # ◯ Work # ◯ Other # _____

Best Time to Call: _____ Ok to Leave Message? ◯ Yes ◯ No

IS TODAY'S VISIT INJURY-RELATED? ◯ Yes ◯ No If YES, What is the Date of Injury?_____

GUARANTOR INFORMATION: <The person financially responsible for the patient >

[ ] Check here if same as the patient above; if not please fill out the following:

Relationship: ◯ Spouse ◯ Parent ◯ Other

Name:

Date of Birth: SSN #:

Street Address: Apt #

City: State: Zip:

Home #: Cell #:

E-mail: Sex: ◯ M ◯ F

ASSIGNMENT OF BENEFITS AND GUARANTEE OF ACCOUNT:

I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is turned over to a collection agency, I agree to pay all costs of collection fees and/or attorney's fees and all court costs if any.

X Date:

<Patient/Guarantor Signature>

INSURANCE INFORMATION:

PRIMARY INSURANCE

Relationship to PATIENT ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: Subscriber Name:

Policy ID #: Group #: Subscriber Date of Birth: Sex: M F

SECONDARY INSURANCE (if applicable)

Relationship to PATIENT ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: Subscriber Name:

Policy ID #: Group #: Subscriber Date of Birth: Sex: M F

HOW DID YOU HEAR ABOUT US? Please circle all that apply:

TV Internet Direct Mail Family/Friends Healthcare Provider Location Other

CONSENT FOR TREATMENT: I, the undersigned, consent to the care and treatment by the attending physician, his/her associates or assistants. I acknowledge that no guarantees have been made as to the effect of such treatment.

Signature: Date:

<Patient signature if patient 18 or older; 14 or older in AL and TN>